CAP-MR/DD Waiver Q and A #2
July 5, 2005

Issue	Question	Response
Transition/Notification to waiver participants	How will CAP-MR/DD waiver participants be notified of the transition to a new waiver?	Waiver participants must be notified in writing by the LME that the current CAP-MR/DD waiver is ending and a new waiver will be implemented. DMH/DD/SAS will provide a sample letter to the LME and post to the Division website. The letter must be addressed individually to each participant and a copy retained in their files.
Transition/Notification to waiver participants	How will consumers and families be educated in regard to the new waiver services in order to support them in making informed decisions about services?	It is the responsibility of the LME and case manager to insure that consumers and families have adequate information regarding the waiver. During the current transition period case managers should be meeting with consumers and families to discuss the new services and to address their questions and concerns.
Transition/Waiver services	The new waiver requires consumers to receive at least one waiver service; what timeline do we give to families who will have to be terminated from CAP if they do not choose to participate at this time in a waiver service?	With implementation of the new waiver, case management will no longer be a waiver service. Case management will now be provided through Targeted Case Management as a Medicaid State Plan service. If individuals currently on the waiver are receiving only case management as a service and no direct habilitation or support services, discussions should be occurring now with those consumers/families to determine the need for waiver services. If the consumer/family does not desire to receive a habilitation or support service through the waiver, they are notified that they will be terminated from CAP effective 8/31/05 and appeal rights are provided.
Transition/Plan of Care and	What Plan of Care format should be used for September	The new Plan of Care is a component of the waiver and

Cost Summary	Continued Need Reviews since the waiver will not actually be implemented until Sept. 1 but the CNR needs to be completed earlier to meet the local approval timelines?	is at CMS for review. It is anticipated that the Plan of Care can be posted early enough for case managers to complete Sept. CNRs.
Transition/Enhanced Respite and PC	If a consumer qualifies for enhanced respite and/or personal care, and it's justified in the plan, doesn't the provider need time to ensure the staff have the necessary training to comply with that definition?	Planning for the transition to new the new waiver should be an ongoing process that is occurring now. Case managers should be reviewing current Plans of Care, assessing consumer's needs with the individual/family and discussing new service definitions now, prior to actual implementation. If through that process it appears that an individual would be appropriate for enhanced levels of personal care or respite the need for additional training of staff should be anticipated. Under the current waiver, the staff training that is consumer specific should already exist and be documented in the individual's Plan of Care as a consumer specific competency to ensure health and safety.
Transition/Enhanced Respite and PC	Will there need to be a Plan of Care update if the service crosswalked is from Respite to Enhanced Respite.	If an individual is in need of Enhanced Respite, the SNAP index score must be computed to insure that the individual falls within the level 3 or 4 of the Utilization Review Guidelines. In addition, the need for the enhanced level must be clearly reflected in the Plan of Care along with the identified additional training needs for the staff. Therefore, the Plan of Care will require an update on the new Plan Update Form as well as an updated Cost Summary and must go through local approval.
Transition/Enhanced Personal Care and Respite	What guidelines do the provider agencies have to follow to determine if someone needs and qualifies for Enhanced Personal Care or Respite?	Whether an individual is in need of Enhanced Personal Care or Respite is based on the person centered plan and the needs identified. The enhanced levels are intended

		to address the intense behavioral or medical needs of individuals and these must be clearly documented in the Plan of Care. An individual must fall within a level 3 or 4 of the Utilization Review Guidelines as determined through the NC-SNAP.
Transition/Individual or Group Services	Are there new instructions on determining if the consumer is eligible for individual or group services.	Group and individual rates are considered in situations in which the individual participates in an activity or setting that has 2 or more waiver recipients, other than facility based or institutional respite. A person should receive group services in these settings if the person's needs can be met by the provision of group services. The need for individual rather than group services must be clearly outlined and justified in the person centered Plan of Care.
Transition/Day Supports	Must ADVPs be licensed in order to provide Day Supports in the ADVP setting?	ADVPs must be licensed through the Division of Facility Services to provide Day Supports. For ADVP providers who are not currently licensed and/or must recruit staff, the provider will have one year from the date of implementation of the CAP-MR/DD waiver to obtain licensure, recruit staff and enroll to provide the Day Supports. The community component of Home and Community Supports may be used during this time frame to support those waiver recipients who have chosen to attend the ADVP. The Home and Community Supports may be provided by a provider agency other than the ADVP. The individual's Plan of Care must clearly document why HCS is being used in these circumstances.
Transition/Day Supports	Since Day Supports will have to be provided by the licensed facility, and the facility is not yet enrolled, is there a hold harmless period that will allow the	For day facilities that are not yet licensed and/or must recruit staff please note the above response. For those who are currently licensed and ready to provide the

	consumer to continue attendance at that facility?	service, the Division has worked with DMA to make the enrollment process for Day Supports as simple as possible. The provider agency will simply complete the NC DMA Application for Provider Participation and indicate the desire to enroll to add Day Supports. They will then attach copies of the license for each facility in which the provider will be providing services and submit the package to DMA Provider Services. The license must be in the name of the agency making the application. The entire process for Provider Enrollment will be posted to the web the week of July 1.
Transition/Day Supports	In many cases, consumers currently receiving Day Hab and crosswalked to Day Supports will actually need to change from their current provider to the day facility provider. How will these providers have time to recruit and train staff for a September 1 implementation date?	As noted above, day facilities that are not yet licensed and/or must recruit staff, the community component of Home and Community Supports may be used for no longer than one year from implementation of the waiver in order to meet the needs of individuals in these settings. The Home and Community Supports may be provided by a provider agency other than the day facility. The rationale for using HCS must be included in the individual's Plan of Care.
Transition/Residential Supports	Occasionally, AFL consumers receive weekend respite. Can the AFL provider bill the Residential Support rate on the day the consumer leaves the AFL (8 am) or the day the consumer returns the next night (9)?	No.
Transition/Crosswalk to new service definitions	Is local approval required before a service order is completed for services crosswalked that impacts significantly the cost summary?	There is no requirement for local approval if only the service names change. If a new service is added (one that does not crosswalk), or if the service duration or frequency changes, the Plan of Care must be revised and approved through local approval. The new Plan Update Form and the new Cost Summary must be used.
Transition/Targeted Case	How does the LME determine the number of Targeted	The number of hours of TCM is based on the needs of

Management	Case Management hours to authorize? Should the LME determine authorization based on the last year's utilization of this service?	the individual and the person centered planning process. The Plan of Care must reflect the frequency/contact schedule for the individual and should be a reflection of the needs noted in the Plan of Care.
Transition/Local Approval	In the new waiver, the LME must have another review to approve plans over $50,000 but under $80,000. Does the second level reviewer have to be the LME's Clinical Director, or is there another designee who can be assigned this responsibility? Will there be additional criteria for this level of review?	Neither the waiver nor the Manual will identify a specific person or position to perform this review; it is left up to the discretion of the LME. However, it is assumed that whomever fulfills this function will have at least comparable or preferably higher qualifications than the local approver. There will be no additional criteria provided as this is intended to be a simple second review for appropriateness of service needs based on review of the person centered Plan of Care.
Transition/CAP Manual	If the CAP Manual will not be written before October, can't the new waiver implementation date be postponed to Oct. 1 as well?	The DRAFT CAP-MR/DD Manual will be posted to the Division website the week of July 1 or sooner.
Transition/Rates	When will the rates be finalized so that the LME can revise its UM software to make the rate/code changes needed before the LME can authorize services?	Rates have been finalized and posted to the DMA website.
Transition/Provider Enrollment	Will current waiver providers have to be endorsed before they can provide the new waiver services?	No. In order to transition smoothly to the new waiver services, the Division has worked with DMA to develop a streamlined enrollment process. This process will be posted to the Division website the first week in July. Most of the new waiver services will directly crosswalk and will require no action on the part of the provider. Both Day Supports and Residential Supports enrollment will require that provider submit an enrollment application along with the submission of their license.
Transition/Service Definitions	Will there be a revision to the Service Records manual for the new services prior to Sept. 1.	The revisions to the Service Records Manual are occurring now.
Transition/Local Approval	If we have to follow the outlined processes in our local	LMEs must continue to meet the requirements of their

	approval policy, Sept. 1 CNRs need to be completed by August 17. Will there be a consequence if we have not followed our local approval policy?	local approval timelines. The Division will provide the necessary information in web postings to insure that the timelines can be met.
Residential Supports	How can a provider of services be reimbursed according to where the consumer resides? Is this not risking the amount, duration, and scope of services that a consumer receives because of where they live?	Residential Supports are intended to meet the habilitation, personal care, and support needs of individuals living in settings outside of their natural home. This includes licensed residential settings or unlicensed alternative family living arrangements. The service is designed to provide flexibility and reflect the natural flow of a person's day. The amount of habilitation vs. personal care is based on the person centered planning process and there are no established hours that a person may receive since it is based on a daily rate. Home and Community Supports are intended to meet the habilitation and support needs of individuals who live in their own home or their natural family home. This also is a flexible service that allows for support coupled with elements of support, and supervision. It may include training and/or support with things such as eating, bathing, dressing, personal hygiene, and mobility, therefore, the need for additional personal care would be limited but based on the person centered plan to address things such as monitoring of health status and physical condition. Neither of these services should result in a reduction in amount, duration, or scope of services, but rather allow greater flexibility in service delivery.
Alternative Family Living	Why do AFLs fall into the same category as group homes in the new waiver as far as the provision of waiver services?	AFLs fall under 10A NCAC 27G.5601 (c) (6) or "F" designation. Although they are exempt from specific rules as outlined in .5601, they are still considered to be

		a Supervised Living setting and are an "alternative" residential setting to their natural family's home. For the purpose of the CAP-MR/DD waiver, an Alternative Family Living Home or Adult Foster Home for one person is provided as an out of home placement for a person who chooses this setting or whose family cannot provide care for that person. The individual receives 24-hour care from and lives in a private home with a family in a home environment where the services are for the care and/or habilitation of the individual. The home does not require a license because it serves only one adult with a developmental disability. The LME and CAP-MR/DD case manager jointly monitor the health and safety of the person. CAP-MR/DD services may not be utilized as payment for room and board costs.
Residential Supports	Since there are no set hours of service for the Residential Supports level, will a provider that provides 4 hours of service be reimbursed even if they provide 14 hours of service?	The intent of the change to Res Supports for individual living in settings other than their own or their family's home is to provide ease of service delivery, less disruption during the day, and to eliminate the need for multiple services during the day. The service may be provided according to the natural flow of a waiver recipient's day whether there is the need for habilitation, personal care, or supervision. The amount of personal care or supervision that an individual receives vs the amount of habilitation is based on needs identified in the person centered Plan of Care and therefore set hours of service are not established. All providers do not bill the same rate as the rate is based on the level of Res Support provided which is determined through the application of the NC-SNAP and the person centered planning process.

Residential Supports	If a consumer lives in an AFL and the services are divided among several providers coming into the home, all providing a different service due to the intensity of care and the needs of the consumer, how will the daily rate be divided if each individual does separate services?	Moving to the Residential Supports definition will eliminate the need for the use of multiple services during the day since the definition allows the provision of habilitation, personal care and supports based on the natural flow of a person's day. This service will be especially beneficial for situations such as this.
Developmental Therapy	Since Federal requirements do not allow waiver services to be provided in the school setting, how will the Division address the need for additional support in the school setting if waiver recipients may not use Developmental Therapy?	The new waiver definitions are very comprehensive and therefore will meet the needs of most individuals on the waiver. However, the Division is aware of the concerns of a limited number of school age children who will be impacted if Developmental Therapy is restricted for waiver recipients. Although this limitation on Developmental Therapy will remain in place, an exemption may be provided to waiver participants who are under 21, enrolled in school and for whom the person centered Plan of Care clearly documents the specific needs and corresponding outcomes for the additional one to one supports in the school setting. The intent of the definition is not to provide an additional aid in the classroom but rather to address the intense behavioral or other support needs that have been outlined in the Plan of Care. Justification as to why the school is unable to provide the support must be articulated in the Plan as well.